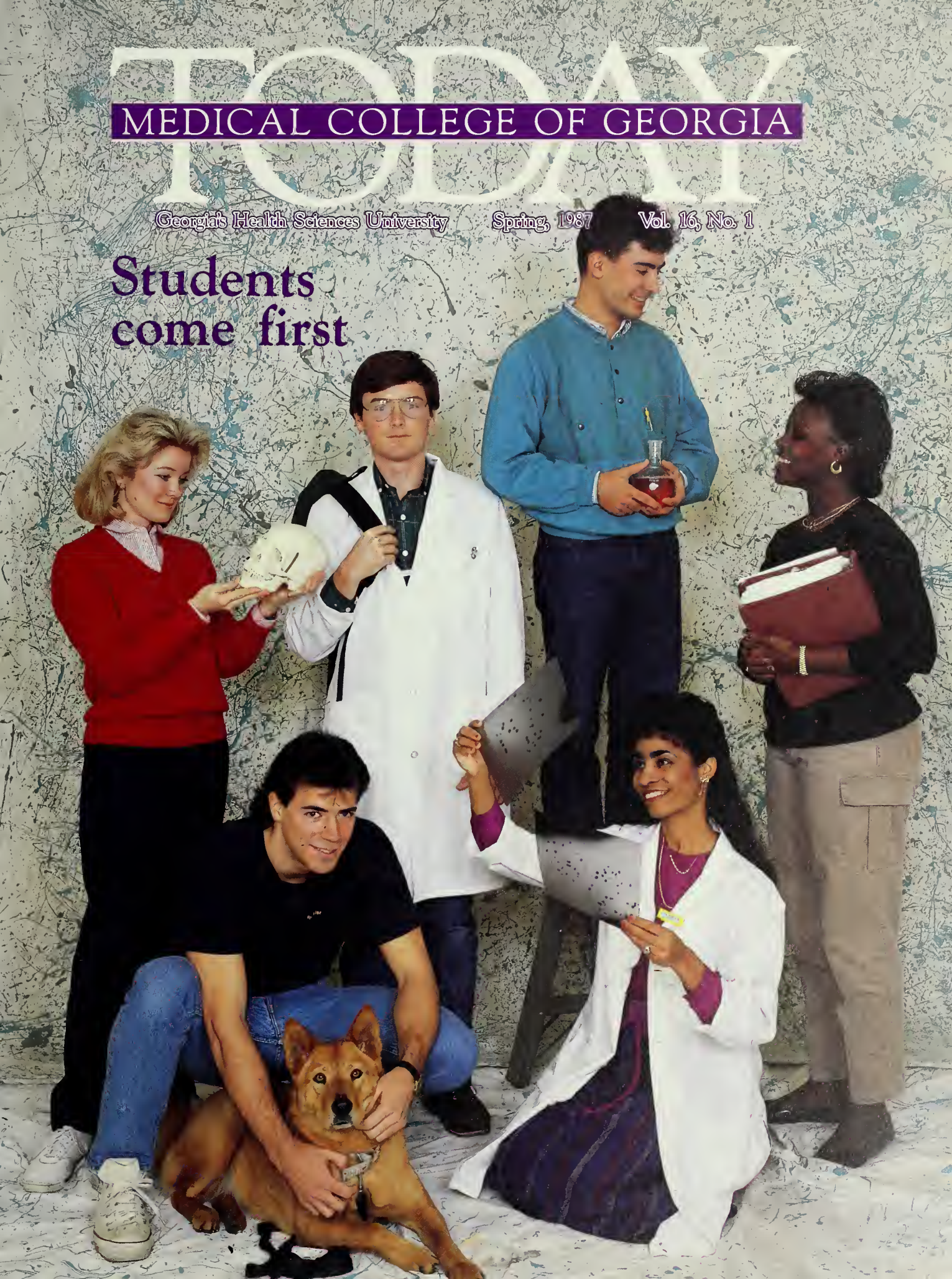
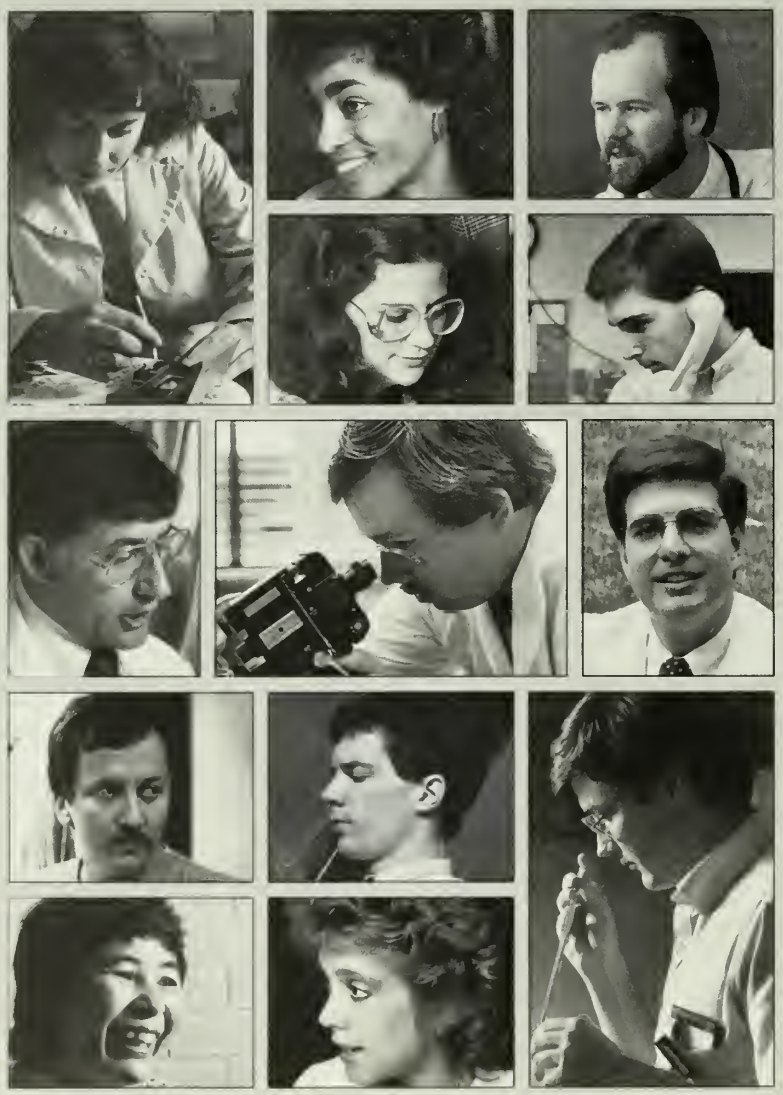
MEDICAL COLLEGE OF GEORGIA TODAY

Georgia's Health Sciences University Spring, 1987 Vol. 16, No. 1

Students come first





The Medical College of Georgia exists first for its students.

In the fall of 1986, enrolled students numbered 2,312. Some came to MCG with baccalaureate diplomas in hand, their eyes on a medical degree. Some came from blue-collar backgrounds. Some put aside the responsibilities of home and family to return to school.

Surgery resident Paul Dickson is the subject of a 24-hour account in this spring issue of Medical College of Georgia Today. Dr. Dickson was an electrician in 1973 when he sat down to watch a television special on cancer. It changed his life. Today he's a fourth-year surgery resident at MCG.

Noriko Akamatsu spoke little English when her husband, a cancer researcher at MCG, died in 1978 and left her with three young children to support. She found a job on campus and began to think about her future. In May, she will graduate from the School of Allied Health Sciences with a degree in medical technology. Her story begins on Page 24.

Other stories in this issue describe aspects of life on campus — the peaks and valleys of medical school admissions, financial aid resources and the Student Government Association — as well as the experiences of students including Julie Jenkins, a master's candidate in nursing, and Steve Csukas, who is researching the effects of aging on the eye in preparation for a PhD in physiology.

Each student is part of the diversity that makes up the Medical College of Georgia. Each plays a part in making MCG one of the best health science universities in the nation.

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The Medical College of Georgia is the health sciences university of the University System of Georgia. Focusing on health care education, research and patient care, the Augusta-based institution consists of MCG Hospital, more than 80 support clinics, statewide outreach programs and the Schools of Allied Health Sciences, Dentistry, Graduate Studies, Medicine and Nursing.

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THE PENDULUM SWINGS

as medical school applications fall - or rise

By Toni Baker

Dr. James B. Puryear likens it to a pendulum that swings.

He first experienced the highs and lows of medical school admissions back in 1969.

America had just put a man on the moon.

The National Aeronautics and Space Administration was cutting back a bit. The pendulum was in motion.

"In the late '50s and '60s there was a big emphasis on physical science and engineering. Much of your top talent was headed in those areas," said Dr. Puryear, vice president for student affairs at the Medical College of Georgia.

But by 1969, when Dr. Puryear came to MCG, the pendulum moved again.

A national doctor shortage was declared.

Nationally, the federal government was giving medical schools incentives to increase class sizes. The Augusta-based school was no exception.

In 1969 MCG accepted 120 freshman medical students.

By 1974 national trends had hit home and pushed that figure to the still current 180.

"A lot of attention was focused on the field of medicine and we began to get more applicants. I can't document this but it's unquestioned that the field of health sciences engineering began to pick up," Dr. Puryear said.

Engineers who might have gravitated to the space program were now attracted to health sciences. The medical technology boom was off and running.

This was part of the pendulum swing.

Dr. Puryear's admissions colleagues from the '50s and '60s told stories about not having enough good applicants to fill a class. Each year they struggled but managed. But Dr. Puryear saw a different time.

With the '70s came a momentum toward medicine.

"Some people say it was because Dr. Kildare was on television," said Dr. Puryear.

But sure enough, without any overt recruitment efforts, the applicant pool began to swell. The grade point average of the applicants was up.

When he came to the medical college, Dr. Puryear remembers telling people the average GPA of an entering freshman was 3.0.

He was rounding it up.

Today the average GPA genuinely is more like 3.5.

"There is the dynamics of it all. Not only did the grades go up, but the number of applicants went up so we were getting a tremendous influx of strong students," Dr. Puryear said.

"The process didn't change, it just became easier to find more students who were qualified. But it became harder to select them because (admissions personnel) were faced with selecting the better of two rather than selecting which one was qualified and which one was not."

In 1974 medical school applicants numbered 40,506 nationally. By 1984 that number had settled out to 35,944.

Today the pendulum seems again in motion.

For the 1986 class, applicants nationally totaled 31,323.

The Medical College of Georgia is not far off national trends.

For the 1974 class, there were 1,585 applicants. That was the first year MCG had 180 slots in its freshman class. Of the 1,585 total, 646 were Georgia residents and 939 were from another state.

By 1984, there were 1,211 applicants, 724 of whom were Georgians. By 1986, the total was 1,018 with 601 Georgians counted among them.

"It's still competitive," says Dr. Mary Ella Logan, associate dean for admissions and chair of the 13-member admissions committee at the Medical College of Georgia.

"There is no question that most of the applicants think the competition is tough."

She is not convinced that just because the applicant pool has shrunk somewhat that competition has lessened.

"If we have 1.5 highly qualified applicants for every position available, it's still going to be very competitive," she said.

"I don't think the admissions committee members ever recommend anybody we don't believe is qualified. We have qualified applicants we are turning away."

Now MCG has a little more than three Georgia applicants for each of its 180 freshman slots in the medical school. Including non-residents, there are better than five people competing for each position.

MCG, a state-assisted university, cannot accept more than nine non-Georgia residents into each freshman medical class. Another consideration is that, as with any medical school's individual pool, most students have applied to more than one school to increase their chances of securing a position somewhere. For an unspecified number, MCG may not be the first choice.

Nevertheless Drs. Logan and Puryear concur that — at least for now — plenty of well-qualified applicants are vying for the designated slots.

"We would like to continue to see very bright, well-rounded, highly-motivated individuals interested in medicine," Dr. Logan said. "I think they still are."

She goes to sleep at night secure that each position in MCG's medical school is filled with a person qualified for the tasks ahead.

"That's not to say that all 180 are equally successful. But I do feel that each position is filled by someone who should be in that position," Dr. Logan said.

It's not that MCG's selection process for these students is a perfect system. But Dr. Logan considers it a good one.

Included in that system are two personal interviews with the best potential candidates. This year that figure totaled 477 people.

The fat years for application brought the luxury of being able to scrutinize

Dr. James Puryear talks with Ronald Young of Athens

these students for more than an aptitude for the mechanics of medicine.

Subjective factors such as compassion, concern and sensitivity are weighed as well. "That's what that kind of applicant pool will allow you to do, to be more discriminating," Dr. Puryear said.

No, that doesn't mean that people who are nice but not bright now get into medical school. Yes, it may mean that the more compassionate of the two smart people gets in.

Drs. Logan and Puryear suspect there are a number of reasons the tide may be turning away from the fat years.

"Two of the factors are the length of time and the cost of medical education," Dr. Logan said. "A few years ago when you talked to high school students, they were interested in how do I get into medical school. Now the questions have shifted more to the area of: 'How long is the training? I have heard that the income of physicians is not going to be as great in the future. Am I going to be able to pay back the loans that I am going to have to take out in order to attend medical school?'"

Students hear about a doctor glut and about exceedingly high malpractice insurance premiums. They may not hear encouraging words from today's practitioners.

But even with the decline in applications nationally, MCG still has a relatively strong pool of applicants from which to be selective.

"We're so much better off than we were before," said Dr. Puryear. He's philosophical about the pendulum swing.

"I think things go in a cycle. That's just my own economic view," he said.

"I would like to be sure that the Medical College of Georgia is able to enroll a number of the top qualified students," Dr. Logan said. "At this time, yes, I think we are. However, unless we plan ahead that may not always be the case because of the increased competition for the top candidates."

Dr. Logan is acutely aware that some changes already have begun.

"Ideally, I suppose, we would like to enroll the first 180 students we select, our top choices," Dr. Logan said. "I don't think it's realistic to expect to do that at the Medical College of Georgia. I don't know of any medical school that enrolls 100 percent of the students they accept.

"I guess what I'm really saying is that . . . I think we on the admissions committee are now more acutely aware of the fact that, not only are we interviewing the applicants, the applicants are interviewing us."

In fact, medical school admissions officers around the country are beginning to think of aggressive recruitment of college students who seem the best candidates for medical school. Traditionally, MCG has taken a somewhat lower profile.

The future may hold not only getting top high school students interested in medicine but also getting top college students bound for medical school interested in MCG. "It's a fine line," Dr. Logan said. So far, MCG still must turn good applicants away. But if the national applicant pool continues to drop, all schools may see a real need to be more aggressive to attract top students.

"I think what we need to be doing is looking to the future and planning for that time when we are going to have to be more competitive," Dr. Logan said.

Dr. Logan believes that the Medical College of Georgia is only as good as its students.

"I believe our students are our most important reason for existing, our primary reason for existing as a medical school. They are our most important asset . . . our product." ■

The long and winding road

Acceptance to medical school only the first of many hurdles

By Toni Baker

James Heaton remembers hooting and hollering. It was a March Saturday. The doorbell rang. He just had a feeling.

"They send you a certified letter that you have to sign for. So you are always sitting around waiting for the doorbell to ring."

If Mr. Heaton had bet money, he'd probably never bet on the doorbell ringing.

He was full of self-doubt; he'd heard all the stories about how tough it was to get into medical school.

But the letter came.

Not only was he accepted into medical school, but he was accepted into the medical school he wanted — the Medical College of Georgia.

"I was yelling and screaming and hollering and jumping up and down. This was where I wanted to be," said Mr. Heaton.

Today, a senior and president of his class, Mr. Heaton reflects on how he nearly didn't apply to medical school at all.

"Everybody who applies knows they might not get in. I think that's a prevailing fear," said Mr. Heaton.

"When you were in undergraduate school back then, everybody said, 'Hey, if you don't have a 3.75 (grade point average) forget it.' That was just the feeling."

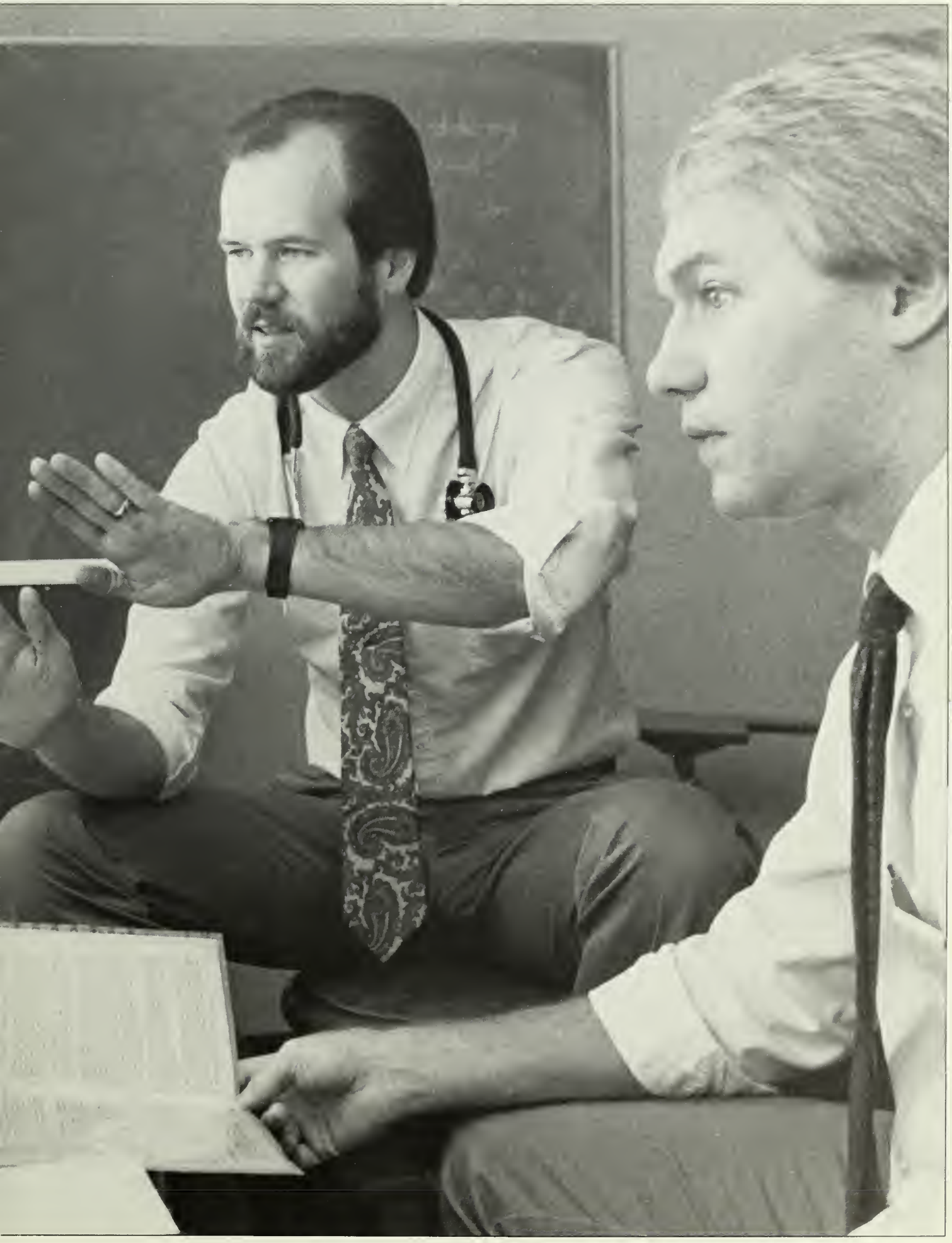
Mr. Heaton didn't have a 3.75. His GPA was more like 2.86.

But he had desire.

He wanted to be a doctor.

"If you're people oriented, it's all the people you can stand. If you are looking for a place to help people, it's the place to be. To me it's still one of the ultimate things to do and one of the ultimate things to know. It has all this room for expansion. It's not an A-B-C, 1-2-3 kind of deal. There is always room

Jim Heaton examines X-rays with classmate Jon York ►



"This is the only thing I can think of you have to put yourself through all this. I wouldn't have done this to go to law school. I want to be a surgeon."

for somebody to do something else, do something new," said Mr. Heaton.

Mr. Heaton even had a role model in his father, Dr. Samuel Heaton. The orthopedic surgeon is an alum of MCG.

But Mr. Heaton didn't have whatever it would have taken to push him forward into the long, arduous process of getting into medical school.

"At that time in my life, I didn't feel like I wanted to be that intense."

At 17, he started college at Mercer University.

"I don't think I was old enough. I hadn't seen enough and done enough and at that point I didn't think I was mature enough."

So he looked to psychology. He'd heard he could accomplish much the same in psychology as in psychiatry and avoid the medical school hassles and potential disappointments.

"For awhile I thought it was going to be neat. I just liked psychology. I was an early '70s person, that's all I'm going to say," Mr. Heaton said with a half-smile.

But the tables turned.

He'd been working at a Macon, Ga., restaurant while in school. After graduation, with his psychology degree in hand, he accepted a job in management at that restaurant.

He was 21. The money was pretty good. He liked the job. He didn't have to make any more decisions.

Until . . .

"I got married in 1979, that always changes the way you think about things." Then the restaurant was sold.

"Here's the big thing probably. Mercer Medical School was opening. I'd always had this desire to go to medical school." But he'd harbored feelings that he probably couldn't get in.

Then his alma mater opened a medical school. Mr. Heaton's father and his brother Sam also had gone to undergraduate school at Mercer. Maybe this was his chance.

First Mr. Heaton had to go back to school for two intense years of science courses. It was tough to go back. He had to work like mad. He had to ignore his wife. But he did it and he did well.

In two years he earned a degree in biology, got a lot of A's and pulled his total grade point average up over 3.0.

He was a viable candidate for medical school.

Or was he?

He was, by then, a full five years older than the other applicants. He wasn't sure how that would go over. He wasn't sure how his background of going from school to work to school would measure up.

He applied to three schools: Mercer, MCG and Emory University.

It was his intention to go to Mercer.

He waited to learn if he'd be going anywhere.

"I was interviewed at all three places, which surprised me. Mercer accepted me first. I still felt very paranoid. I just didn't think I was going to get in (at MCG).

"The waiting after the interviews is the worst, five or six months of wondering and wanting to get on with life. I'm a big worrier and this gave me plenty to worry about."

Then came that fateful March Saturday.

Mr. Heaton thought, for a fleeting moment, that his troubles were over.

"I was pretty innocent. I thought, once you got into medical school, life was set. But it's not."

Nearly four years later, he is trying to get into a residency, an orthopedic surgery residency to be precise. "To me, it's much more anxiety-provoking than trying to get into medical school. If I hadn't got into medical school, I would have done something else."

But now he's waiting again, waiting to hear if he'll beat fierce competition for a spot in an orthopedic residency program.

"We all spend thousands of dollars going all over the country trying to find a spot. Then, you never know where you stand.

"(Interviewers) may be telling you they are ranking you number one. They may be telling that to everybody, because the students tell them they are ranking them number one and they are telling a lie, too.

"There's a lot of people who say it doesn't matter, that there have to be other things you want to do. You can be happy doing anything in medicine.

"I don't feel that way," said Mr. Heaton. "When you feel honed into what you want to do, each time you get to (a crossroads) you feel like you are going to be rejected."

The fact is Mr. Heaton hasn't been rejected yet. In fact, he was accepted the first time. MCG has had students apply for medical school as many as seven times, coming back time and again as they try to make themselves better candidates by taking more courses or getting work experience in a hospital.

Yes, Mr. Heaton understands things could have been much worse. No, he wasn't rejected. But he could have been.

He doesn't think he would have gone through such emotional agony for anything but medicine. He pauses. "This is the only thing I can think of you have to put yourself through all this. I wouldn't have done this to go to law school. I want to be a surgeon."

So he wrestles with this latest dilemma. Will he get his residency or won't he?

"Maybe I'm just being set up for the big one." ■

MAKING THE ROUNDS

By Toni Baker

For most of us, Friday afternoon means the work week is winding down. But residents on weekend call know their schedule doesn't let up until Monday. Writer Toni Baker and photographer Elizabeth Harrington produced the following account after spending 24 hours with surgery resident Paul Dickson.

7:37 a.m. Dr. Paul Dickson is looking for coffee. He's on the long end of a hard week. Somewhere in the endless days of that week, the Medical College of Georgia's Shock Trauma Service admitted its 2,000th patient. Somewhere during the short nights, he managed 18 hours of sleep. Now it's the weekend. That means he won't be seeing his own bed until at least Monday night.

7:56 a.m. The day begins unhappily. A young father and husband who is a patient in the Shock-Trauma Intensive Care Unit seems on an irreversible course. Dr. Richard Treat, chief of the trauma service, breezes into the unit. He wants to know about the patient's neurological status. "As of the time I left yesterday, it was indeterminate," Dr. Dickson tells him. "I haven't talked to Cody today."

Dr. Cody Gunn is the other fourth-year surgery resident on trauma. Dr. Dickson, the resident coming on call, decides he'd better check with the one going off. They will do this officially in routine morning rounds. But Dr. Treat, the attending, wants to know something now. Dr. Dickson won't wait until rounds. "Dr. Treat was here and asking questions. I just wanted to know since I was being asked and I have no answer better than I don't know," he says. The news from Dr. Gunn is not good. Dr. Treat tells Dr. Dickson to call the wife and have her come to the hospital. He also wants the neurosurgeons called to make a final assessment.

8:06 a.m. Dr. Dickson finds a semi-quiet corner in the Shock-Trauma ICU and makes the call. The wife is having an understandably difficult time. Dr. Dickson encourages her to bring her mother-in-law. She'd be of help, he tells her.

"Nobody likes to make those kinds of calls," Dr. Dickson says. "On the trauma service it's somewhat easier because Dr. Treat tends to do a lot of the talking. He doesn't want you to step on your toes with your words, make a verbal mistake that will change the family's perspective of what is going on. He likes to somewhat be in control of that. Like we were talking about. This is perfect and this is not. We do it this way, every time. On other services we may have more direct contact with the family and patients. But it's never easy."

8:40 a.m. The neurosurgeons arrive en masse. They have no better news. By then, Dr. Dickson is aware that he has missed Saturday's grand rounds. He's also missed the regular Saturday morning quiz the surgery residents take. It's one of surgery department chairman Dr. Arlie Mansberger's ways of making sure his residents keep reading and keep on top.

9:15 a.m. The patient is declared dead. "The only time I guess it's easier is when the family member is 80 or 90 and you can say, they have been sick for so long and this is actually better for them," Dr. Dickson says. "But when it's a young person who you are dealing with

9:14 a.m.

in trauma, nothing you can say is going to make it better unless they have just suffered a long time. You've heard the rap. It's the number one killer (of young people). You never know when you walk out that door that you won't be coming home, not in this world."

Dr. Dickson knows the story nearly too well. He was a trauma victim, his right leg shattered by a booby trap in Vietnam. Years later and now years ago, when he was an intern, his wife Sherry was a patient on the trauma service he now staffs. Both experiences made a lasting impression.

As a corpsman attached to a Marine unit in Vietnam, he found himself wanting to do more than just bandage up soldiers and send them off on helicopters. Later, as a bandaged soldier himself he faced the possibility of losing his leg. He was scheduled for the amputation. The day before, a surgeon came to see him.

"He looked at my leg and said, well, this looks a little bit better today," Dr. Dickson says.

The next day, the scheduled day for amputation, the surgeon came back, this time to say he didn't think the leg had to come off. "He was using just a lot of gut sense. In the military, it's a lot easier to just cut something off, ship you back to the States instead of trying to rehabilitate you. But he saved my leg. I don't even know his name."

His wife's experience left him acutely aware of the damage that can be done at 30 mph on the battlefields we call roads. Her fractured knees still haven't completely recovered. Today Dr. Dickson always wears his seat belt. He's a believer in prevention.

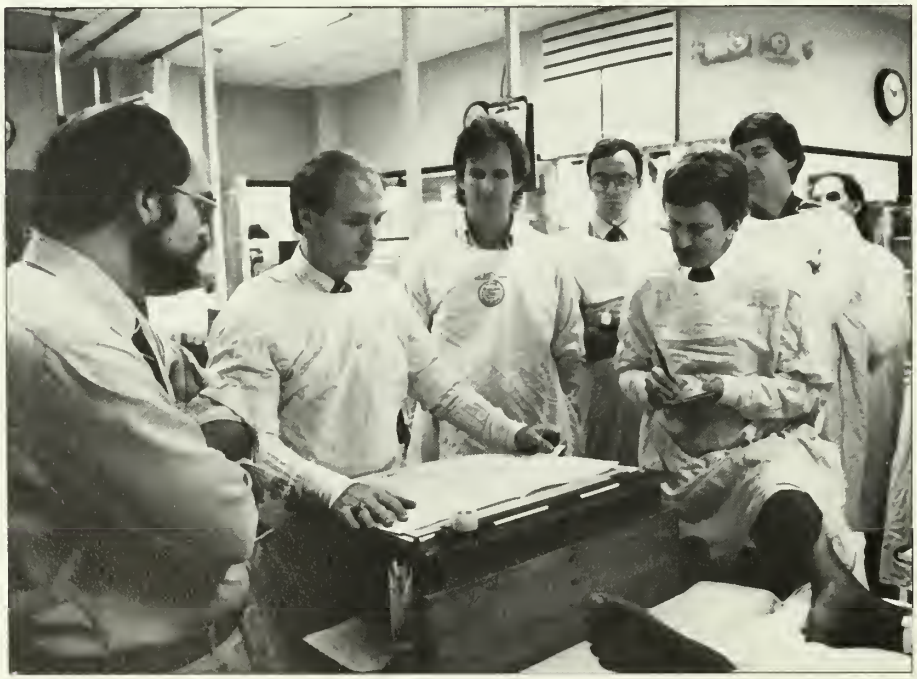
9:26 a.m. Dr. Dickson talks to the patient's family. The wife thanks him for what was done. He reminds her that she must take care of herself. The family is left alone with their loved one.

But the work isn't over. An autopsy will be done to learn more about the cause of death. It's apparently a relentless infection. Also, the MCG Eye Bank must be called. The family wanted the patient to be an organ donor. Unfortunately, the infection that took his life also made it impossible to donate anything other than the corneas for research.

Dr. Dickson calls the South Carolina coroner to notify him of the death. The accident occurred in that neighboring state. The coroner says he doesn't want an autopsy, just send him a statement of death. Dr. Dickson has in his hand a signed consent from the wife for the autopsy. He has talked to the pathology resident to arrange the autopsy. Everything seems set.

10:04 a.m. Rounds begin. Dr. Gunn informs Dr. Dickson on the status of each patient he'll be responsible for over the next three days. Tomorrow Dr. Dickson will be in the "hot seat" of responsibility. Rounds begin in the Shock-Trauma ICU. The group works its way to the fourth, fifth and eighth floors. Dr. Rodney Durham, the trauma surgery attending on call for the weekend, troops around with the group, asking questions of the residents, explaining how to handle problems. The teaching and learning process is a continuous one. The patients represent a mixture of problems and needs. One stepped in front of a car. One went through a windshield. An elderly man, already the victim of a stroke, was beaten with a hammer by robbers. Another patient's car was hit by a speeding vehicle. Another tried to commit suicide. Another skidded more than 70 feet across asphalt. The young doctors store enormous amounts of information on each patient, remembering vitals like urine outputs and drug dosages.

11:40 a.m. Dr. Dickson needs to finish up paperwork on the dead patient. About the time he plops down in the unit, Dr. Treat returns. Apparently Dr. Dickson has done something wrong about the autopsy. He's not sure what. He is sure Dr. Treat is unhappy. The



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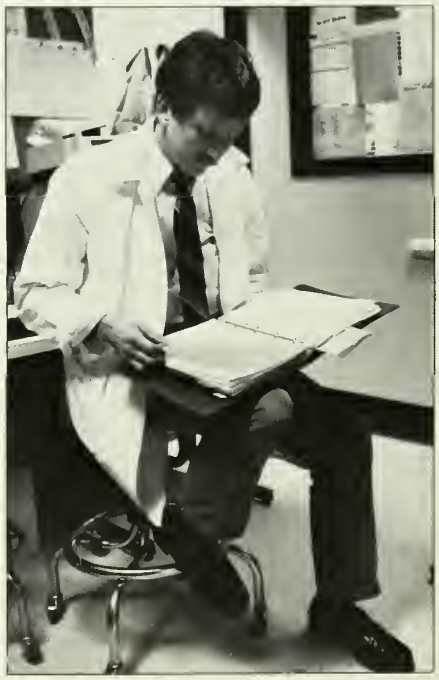


11:45 a.m.

family agreed to the autopsy. The coroner has said fine, just send him a statement of death.

"I think the problem is should something come up and there's a legal action, there could be some trouble," Dr. Dickson says, shaking his head over the unclear mistake. Apparently there is a specific autopsy permit for cases in which the coroner doesn't want the autopsy. The permit absolves MCG pathologists of potential legal consequences. In other words, the pathologists wouldn't have to go to court if the coroner does get interested in the case.

"Treat says we have them," Dr. Dickson tells a clerk. "Is there anything else we have here besides what you gave me?" he asks. But the only form the clerk can find is the one that was signed. "I think what we've got here is not a special request, but that I should have contacted you before the consent was signed to see if y'all would do it, legally," Dr. Dickson tells the pathology resident. "I'm trying to figure it out, too, because Treat was just upset with me and did not really tell me exactly. I was supposed to have some packet of stuff to read before doing all this stuff and I didn't." Dr. Dickson asks the pathology resident to call the pathology attending and let him know if everything is OK.

Noon. Dr. Dickson finds a few minutes to talk with the wife of a minister who had been critically injured days before.

"Over the night, he really did pretty good. Nothing really changed. We're making some minor adjustments. His right hip is redislocated and the orthopedists are probably going to give him some sedation in the unit and place it back in the socket where it is supposed to be and put it into skeletal traction to keep it in place.

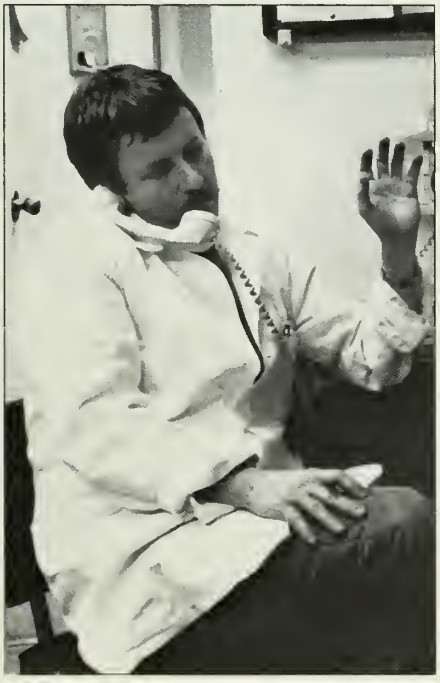
"Overall, he is basically stable. Overall, he looks pretty good. He had tremendous injuries but he looks like he's doing pretty good. We've got to watch him real close and stuff. We are not out of the woods or anything like that, but for the injuries he sustained he is doing much better than I would have suspected. Hopefully, we are going to get through all of this. He's got the best man in the world helping him," Dr. Dickson says, referring to the preacher's relationship with God.

"He is strong-willed. We are going to work real hard to get him out of here. But, like I said, we are not over the hump. We've just got a ways to go. He's still critical, but he's stable." This wife is easier to talk with than many. She is a nurse and so understands more readily much of what he tells her. Still Dr. Dickson isn't one for much jargon. "If we don't see you and you want to talk to us, just call the unit," he tells her. "If we are available, one of us will come out and talk to you."

Then it's back to Shock-Trauma ICU. Dr. Treat calls. Dr. Dickson tells him that he's waiting to hear from the pathologists. Yes, he's gotten equipment needed for the next procedure. The conversation then focuses on the autopsy. "Is there any other way out of the hole? Could I talk to the coroner again?" At that time, the attending pathologist says he will do the autopsy. "I'll see if I can get in touch with the family and get the additional permit for the coroner's report," Dr. Dickson says. He hangs up the phone.

Now the pathology resident is confused. "Hell, I didn't know what it was. He's just telling me now what he could have told me three minutes ago instead of jumping my case without saying anything," Dr. Dickson says. The pathology resident is sympathetic. His attending is upset as well. "What he is saying now is what if the coroner decides three days from now that he wants a report, he can't get a report from y'all." The pathology resident says he'll call the coroner to straighten things out. Dr. Dickson says to please let him know what he finds "so I can get that taken care of and get this mess straightened up."

The mess is that every state has a coroner or medical examiner to deter-



12:30 p.m.

12:45 p.m.

mine a patient's cause of death. But the law doesn't give these officials access to the dead patient's medical information. So at the time of death, the doctor caring for a patient must get a permit signed by the family enabling the doctor to give the information to the coroner. Getting that form signed is a matter of standard procedure. Dr. Dickson now knows that. He also now knows that the form is in medical records.

12:45 p.m. Up to the fourth floor burn unit to change a dressing on a major injury that goes clear to the bone.

1:30 p.m. To the autopsy room. "It's good for us to know what really caused him to die," Dr. Dickson says. "Like I said, he looked initially like he had a survivable injury. We looked at everything we knew to look at and didn't find it. Now this is the only way to find it. It just helps us take care of patients in the future. We might look harder or differently at another patient." Immediately on autopsy the cause of death still appears to be relentless infection. Later, when all the tests are in, infection is proven guilty.

2:22 p.m. Back to the Shock-Trauma ICU to check on a patient who is swelling, trapping large amounts of air and fluid under his skin.

2:40 p.m. Back to the Surgical ICU.

2:50 p.m. Back to the Burn Unit.

3:15 p.m. Lunch.

3:30 p.m. Lunch is over.

3:55 p.m. Back to the intermediate care unit. Dr. Dickson's beeper provides a constant rhythm throughout the day and the night to follow. Nurses call to update him on a patient's urine output or some other status. Physicians, such as Dr. Durham, keep checking with him. Shortly after 4 p.m., he makes his first stop at the trauma on-call room, shedding his street clothes and loafers for scrubs and New Balance running shoes. He's prepared for whatever Saturday night might bring.

"You have to become confident," says the 37-year-old who survived stints as a wartime medic and later as an electrician before he pursued his dream. "My confidence level compared to most surgeons is low. The way I do things is to continuously beat myself and say how lousy I am so I have to work harder. I'm like Avis. I'm number two and have to work harder."

He gets more serious. "There is nothing else except surgery for me. I mean there is no good explanation."

He did three radiology rotations in school "trying to love that." He liked it, temporarily. Radiology promised a "fantastic living" without the hours of surgery. But he just couldn't.

"I think the Vietnam experience had a lot to do with being a surgeon. The place I really fell in love (with surgery), we were operating on a 250-pound woman, doing a gallbladder. I was on the end of the retractor pulling her rib cage up, looking in trying to see something about surgery. I knew that day I was going to be a surgeon." He was a junior medical student.

"Just opening up the human body and watching it be alive. I don't know. That was the neatest thing in the world to see that person's skin cut and see that you are doing this and that this person is living and that you are making them better with surgical intervention. I knew that's what I wanted to do. I just love to watch the body work. It's neat. If I'm going to do something like this, surgery is all I want to do.

"This is a miserable lifestyle basically. But when you operate, it's different. It's like your reward for beating yourself to death 75 percent of your time. It's a heavy responsibility yet it's a neat feeling, too, knowing that you've got that control. I don't know of anything I'd really be happy in. All the other things I could have gone into, I could have been finished by now."

2:22 p.m.

2:50 p.m.

But there is no real option for Dr. Dickson. The thought of quitting surgery has and does cross his mind. He's already received an offer from a small town to come ahead and practice. But he says he'd be a fool to do that. "I get tired of being somebody else's boy, yet I realize that I'm not ready, so I have to finish." He noted Dr. Treat and the love-hate relationship that can develop with this demanding man who doesn't understand second best. "No matter whether you are loving him or hating him at that moment, if you need him, he's right there in the trenches with you. On traumas he is sitting there drawing the blood work." In fact, depending on how Dr. Dickson survives this 2 1/2-month stint and his next with Dr. Treat, he just might consider trauma surgery.

5:43 p.m. The emergency room calls. A young patient with a flash burn needs his attention. Dr. Dickson looks the young man over and calls Dr. Durham. The patient was working on a gas furnace and the flames shot out at him. He has mostly first degree burns up to what's left of his widow's peak and a couple of other blistered areas, particularly his nose. Some of the burn looks deep enough to convert to second-degree burn. But Dr. Dickson's main concern is an inhalation injury. He tells the patient it might be best if he stayed the night just for observation. By 6:20 p.m. the wife has arrived, the burns have been treated and the patient is agreeing to stay. Dr. Dickson takes his time with the young couple. She is pregnant. Her husband is concerned about her. She is concerned about him. Dr. Dickson is concerned about them both. He leaves, believing the young man will take the safe route and spend the night. Shortly after 7 p.m., the beeper goes off again. This time it's a call saying that the man decided to leave.

7:43 p.m. Rounds again to check on everybody. Dr. Dickson requests a dressing change on the minister's bad fracture so that he can look at it.

"Robert, are you hurting, buddy? Let me know if you are. The doctor just wants to take a look at the traction we've got here on your foot," registered nurse Charles Slusser tells the patient.

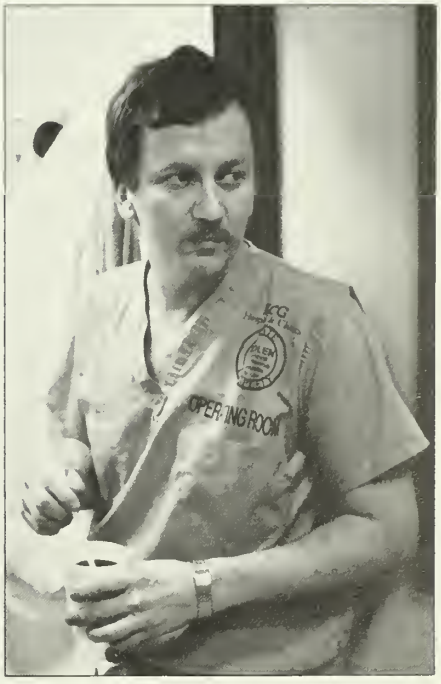
Back upstairs in the Intermediate Care Unit, Dr. Dickson looks in on a young man with a bad head injury. "Randy, how are you doing today?" Earlier in the day, Dr. Dickson moved the patient to this unit to make room for a sicker patient in the ICU. He tells the patient he's in the same hospital, just a different place. "You want to get better, don't you?" The patient nods a response. "That was amazing. That's the most responsive he's been," Dr. Dickson says, flashing a smile.

He strides back over to the on-call room to take advantage of a few minutes of quiet. The night is passing. No new trauma admissions have come in this Saturday night. Yet, the pace is constant, busy. Decisions always have to be made. Details have to be remembered. He's not totally convinced this baptism by immersion is the only way.

"I think you can be too tired to learn," he says. But as Dr. Treat says, if you can perform tired, it's no problem when rested. "So you learn to do it while you are tired so you can function better when you are awake. Sometimes, out in the real world, you are going to be tired. You have to be able to function. (But) I think it would help us if we weren't on call so much. We are expected to work long and we are expected to work hard hours. We are expected to be the best. Who wants the worst? I would like not to have to work so hard to be the best," Dr. Dickson says. But his actions belie his words.

He had a job. He had a home. He had a family. Yet he put away the relative certainties of his life to get himself deep in debt and tired beyond belief. "I didn't want to be 50 and say I wish I had. I'd much rather be 50 and say I wish I hadn't." He'd just come off the tennis courts on a sunny May day

10:30 p.m.



1:30 a.m.

in 1973 when it hit him. He flipped on the television to the Public Broadcasting Service, not a habit, and sat mesmerized for two hours as a cancer special unfolded. "Maybe I was unhappy with what I was doing. The program hit home. What are you doing? You could be doing something for somebody else. This is not BS. This is the truth." Within the next week he got a transcript of his high school grades and a copy of his Scholastic Aptitude Test scores. Two weeks later he was a student at DeKalb Community College.

Probably as a safety net, he also pursued an electrician's apprenticeship. He went to both schools by night and worked full time by day as an electrician. He finished the apprenticeship, took what courses he could at DeKalb and then transferred to Georgia State University. By then, his wife had finished nursing school. He went to school full time. In 1978 at age 29, he became a medical student at the Medical College of Georgia.

"The only reason I got into medical school was they needed a minority — a beer-drinking construction worker," he says. Once accepted, he couldn't wait to get to school, to begin to learn all that he wanted to know. The first two years of book-learning were tough. "The third year I finally got to what I wanted to do which was taking care of patients. I was not AOA (Alpha Omega Alpha). Probably more like Charlie Omega Charlie would be my fraternity."

Later that night he gets more serious.

"I'm not the typical MCG resident. They usually are AOA, top-of-the-line medical students. I've got a good personality, but that didn't get me my residency. I worked my can off. As far as books and academics, I was not the greatest in medical school. When I got to clinical rotations was when I excelled. There are just some things that come from the gut you can't get out of a textbook."

Yet he knows enough to know he doesn't know everything. "If I don't know, I'm not embarrassed to let somebody know I don't know. The patient comes first. I mean, if I have to get ridiculed because I don't know something, I'll ask. It's one way to learn. I've never forgotten anything I've been chewed out about. I'm not going to hurt anybody by not knowing. The patient is number one. (That's) a Treatism."

8:48 p.m. Dr. Dickson is worried about a patient's possible neck injury. He orders up a CT scan, then breezes through the emergency room to see what's up. It's one of those unusual Saturdays. All is quiet. The patient's scan is done within the hour. It's determined he needs the orthopedic service. By 10:22, the patient is settled on that service. It's back to the on-call room and to bed by 11:30 p.m. But the beeper stays busy. One patient, the one whose swelling caused concern earlier, has worsened.

1:30 a.m. Dr. Dickson is back in the Shock-Trauma ICU perusing the patient. The patient is getting lots of fluids but he's not making any urine. His lungs are showing white on X-ray. His pulse and temperature are up. All could indicate early signs of infection. The patient has a closed head injury and a severe liver laceration. Dr. Dickson decides to insert a Swan-Ganz catheter to measure pressures in the heart and lungs. He tells someone to summon the on-call medical student — the mullet — so he can share the experience. "A mullet is a fish that lives at the bottom of the sea, eats scraps and doesn't make waves," Dr. Dickson explains. "Senior mullets are a little bit bigger fish that rise a little bit higher in the water and still don't make waves. Then you have the interns who are super mullets. We consider ourselves all mullets because somebody is above us." It could be worse, he says. In Kentucky the term is slug.

With everyone quickly assembled, the catheter is placed. The numbers are telling. The cardiac output, heartbeat and other indicators do not indicate infection. Dr. Dickson will give more fluid to slow the heart and make it work more effectively. He'll try improving on the patient's oxygen availability by improving his cardiac function. He orders a liter of fluid to be pushed over the next hour.

3:30 a.m. Back to bed.

4:33 a.m. The Shock-Trauma ICU calls to update him on the status of the two patients and ask for any orders.

5:15 a.m. The young woman in the burn unit who had the dressing changed earlier in the day now has a creeping temperature. It's the body's normal response to infection. Dr. Dickson orders a cooling blanket for her.

7:31 a.m. This time the shrill noise is the alarm. Dr. Dickson rises slowly but surely. Another resident beat him to the shower. He performs a perfunctory wash at the sink and heads out the door. "I have to go see patients." ■

3:00 a.m.

Unraveling the body's secrets

Three graduate students conduct research to help solve medical mysteries

By Gwen Corinth

Explaining the causes of cataracts

Steve Csukas may seem more absorbed than most 29-year-olds in the inevitable future: growing older. It's not that he's worried about crow's feet or a spare tire. As a graduate student in physiology at the Medical College of Georgia, he is interested in the broader picture. Scientists, physicians and a population growing older are all interested in the answers to a single question:

Why does the body age?

"We're hoping in the next hundred years to get rid of most causes of death and disability," he said. "All that's left is why you die. Why is there a limit to your lifespan?"

Specifically, Mr. Csukas is working with Dr. Keith Green of the MCG Department of Ophthalmology to study what causes changes in the eye as it ages. The result of such changes is often a cataract, the gradual clouding of the lens which can lead to blindness.

Mr. Csukas's research focuses on the gradual deterioration of enzymes in the eye which protect the membranes of the cornea and lens. As the eye ages, enzyme levels appear to drop. Mr. Csukas hopes to discover if this enzyme decrease is related to the development of cataracts.

"We've shown enzyme levels drop with age in a rabbit," he said. "If that happens, you can get changes we normally see in old people — cataracts in the lens, damage to membranes in the cornea and lens."

One reason for this damage may be the presence of hydrogen peroxide, which exists in higher levels in the eye than elsewhere in the body. Another may be the presence of free radicals, chemical by-products of body processes which can break down cell membranes and cause tissue damage. Enzymes in the eye function to break down both hydrogen peroxide and free radicals.

"In cataract patients, the hydrogen peroxide level is often two or three times that which is normal. We don't know if that accompanies (cataracts) or causes them," he said.

One way of testing the theory is to inhibit the production of the enzymes and observe whether a cataract develops. Five of six rabbits tested have shown some clouding of the lens, Mr. Csukas said. He later plans to measure levels of hydrogen peroxide in the rabbits' eyes.

Ultimately, if hydrogen peroxide is shown to cause eye damage, Mr. Csukas may experiment with a compound which can be administered in drops to lower peroxide levels. But that is very speculative now, he said.

After graduating in June with a PhD in physiology, Mr. Csukas hopes to go on to a postdoctorate at the University of Louisville. It's not exactly what he had mapped out for himself a few years ago. While in high school and college, he trained to be an emergency medical technician and worked in a hospital emergency room with eventual plans to become a doctor. Now he plans to spend his career in a laboratory, doing what he enjoys most — solving problems.

"Problem solving is what research is. I've always been good at problem solving," he said.

"And it's challenging — you don't always get (the desired) results. You've got to figure out what went wrong or why those results happened."

The technology of science and medicine has always interested Mr. Csukas more than patient treatment.

"When you work with (patients),

Steve Csukas

you're solving a problem that already exists. You're treating them after the fact whereas I was interested in knowing the causes."

Understanding aging may require several lifetimes of research, and Steve Csukas doesn't pretend to imagine the questions will be answered during his career. "It's too complicated a problem. I think we only have a few of the clues to solving it," he said.

Ethicists may raise questions, too, about quality of life and living longer. He has a ready answer for that.

"If I find a drug that could make you live another hundred years, I'm not going to force you to take it. But I'd like to give you a choice."

Discovering how a fetus is nourished

While his classmates make rounds in the hospital across the street, 26-year-old Daniel Balkovetz works amid test tubes and chemical solutions in a lab on the second floor of the Research and Education Building.

As a sophomore medical student, he could have been on clinical rotations with the rest of his class. But Balkovetz opted for time out to complete a PhD, which means he'll be two years behind his class in finishing medical school.

Medical students call it delayed gratification: investing time and money in a lengthy education and launching their careers at an age when many of their peers are buying second homes.

Mr. Balkovetz calls it good sense.

"I'm happy with my decision," he said. "I enjoy the everyday challenge of my research, especially when my experiments work as planned. Also, my research may help me obtain a residency at an excellent medical institute."

Mr. Balkovetz, who will graduate in about four years with an MD/PhD degree, wants a well-rounded education for a career in education, patient care and research. He weighs all three equally and ultimately hopes to work in a teaching hospital.

Now he's working under the guidance of his major adviser, Dr. Frederick Leibach, spending 10-hour days in the lab researching solute transport in epithelial cells, which translates to how nutrients and electrolytes are absorbed in the human body. Specifically, he and a colleague, Dr. Vadivel Ganapathy, assistant professor in cell and molecular biology, are using the human placenta as a model for showing how nutrients are transported from mother to fetus.

Daniel Balkovetz

Using membrane from the placental lining, Mr. Balkovetz has so far studied the transport of electrolytes, peptides (blocks of amino acids), vitamins and amino acids. The membranes are made into vesicles (sacs) and soaked in a solution containing the substances. Then the vesicles are removed from the solution, and amounts of the transported substances are measured.

Part of the study is also to determine energy sources that fuel solute transport. For example, the fetus has a greater concentration of folic acid in its blood than does the mother. Therefore, folic acid must be actively transported from maternal to fetal blood.

What Mr. Balkovetz learns may be helpful to obstetricians trying to understand the causes of fetal growth retardation. The placenta is the medium of exchange for influential drugs as well as nutrients.

Meanwhile, research is challenging exercise for an analytical mind like his own, Mr. Balkovetz said.

"It's very satisfying. It gives you a good feeling when you work on a problem and you're able to solve it or elucidate how something works and receive recognition for it."

He works with two postdoctoral fellows besides Dr. Ganapathy: Dr. Yusei Miyamoto from the University of Tokyo and Dr. Chinnaswammy Tiruppathi from Washington University in St. Louis. As a team, they keep up with related research in journals on physiology, biochemistry, obstetrics and gynecology and pharmacology.

Mr. Balkovetz believes his work will pay off by making him a physician who understands the disease process.

"I'm developing a better knowledge base in medical science."

Tracking down clues to AIDS

Pandemonium is not too strong a description for what happened when Angela Hankinson began her masters research project a year ago.

Once word got around that Ms. Hankinson was experimenting with a DNA clone of the AIDS virus in search of a diagnostic tool, her co-workers in the Carl E. Sanders Research and Education Building were nervous about sharing lab space and equipment.

"They didn't want me to use the centrifuge — they didn't want me to use anything!" said Ms. Hankinson, a 25-year-old third-year graduate student working on a master's degree in microbiology.

But Ms. Hankinson was able to convince them their fears about infection were unfounded. Her research requires only a fragment of a clone of the DNA virus, which is therefore inactive and incapable of infection. The only potential hazard is working with the serum of AIDS patients, but Ms. Hankinson takes all precautions — wearing mask, gown and gloves while working in a containment area.

Still in the early stages of her research with Dr. Fred Garver, Ms. Hankinson is trying to subclone the DNA corresponding to a portion of the envelope, or outer covering, of the virus into a plasmid vector, which is a transport vehicle enabling the DNA to move into a bacterial host. The plasmid is then placed into the host and the envelope protein is produced. Sera taken from patients at various stages of the disease is tested to see if this protein will react with each sample. If this works, the protein can be used for diagnosis or for a vaccine preparation to stimulate formation of antibodies.

Patience is at a premium when working with microorganisms, Ms. Hankinson has found.

"I am still trying to get a clone," she lamented in November. "I've had many unsuccessful attempts."

"Nothing is as straightforward as it appears. For example, adding a restriction enzyme and its buffer to a relatively crude DNA preparation may result in an incomplete reaction or complete deterioration of the DNA — problems which force you to backtrack."

Results are difficult to see, too, because DNA isn't visible to the naked eye. To observe the results of experiments, the components are placed in a gel stained with fluorescent dye. For example, an initial indication of a successful ligation (the first step in cloning) is the upward shift of the dye-stained DNA when viewed under ultraviolet light.

If the cloning experiment is successful, it can be verified by detection of the DNA of the envelope gene within the bacterial host or by production of the envelope protein.

The work is challenging too because AIDS research is of such urgent interest both for scientists and the public.

"It is such a hot area now. There are so many scientists involved . . . so many people dying," she said.

"It also means I need to hurry up and have a breakthrough. If someone else accomplishes this first, my project may become invalid."

Ms. Hankinson reads about other AIDS research in journals and newspapers. But if another researcher beats her to her goal, all will not be lost. The project is planned with built-in flexibility.

"If someone does the same work, I can probably use the subclone, but I must modify the application of it," she said.

Ms. Hankinson started her association with MCG as a lab technician working for Dr. Jim Hill, then of MCG's Department of Cell and Molecular Biology, who encouraged her to enroll in graduate school. She came to MCG with a bachelor's degree in psychology and a minor in chemistry and planned eventually to go to medical school.

"(Dr. Hill) said I asked too many questions, that I needed to go to graduate school," she said.

Ms. Hankinson hopes to finish her master's and then study for a PhD. Eventually, she'll probably work in a hospital or an industrial research laboratory.

She enjoys research, but not to the exclusion of all else.

"I like this because I can appreciate the significance and worth of its application, but I also like to interact with people," she said. "I don't think I'd be content pouring plates, growing cultures or loading gels indefinitely — research for research's sake." ■

Angela Hankinson

Don't call him doctor

Jerry Marcotte is a nurse and proud of it

By Christine Deriso

Jerry Marcotte epitomizes an atypical member of his field. The Medical College of Georgia graduate student is a former football star, an Army retiree and a grandfather. He isn't exactly what one imagines a nurse to be.

But that's what he is, and has been for 22 years. And it's a vocation that ignites his passion, though he wouldn't have guessed it until he started college.

The Illinois native had his sights set on an engineering degree when he began college in 1960. But he was playing football and his grades suffered, so he abruptly changed course.

"My mother suggested nursing school," he said. "She was a nurse and I had worked part time as an orderly. She sensed that I enjoyed that."

So the die was cast. Mr. Marcotte transferred to Chicago's Alexian Brothers Hospital School of Nursing, received his certificate, and proceeded to De Paul University in Chicago where he earned a bachelor's degree in nursing.

Alexian Brothers was an all-male school, so he had yet to be initiated into the ranks of a minority. But at De Paul, he estimates that there were 100 women for every man in the nursing school.

"It wasn't intimidating only because I didn't stop to think in terms of a male-female ratio. In an academic environment, you don't get put down. Everyone is looked upon as an equal."

Once out of school, he found that a different set of standards applied.

He joined the Army Corps of Nursing, and despite the higher ratio of male nurses in the military (about 20 percent, compared to about two and a half percent in the civilian sector), he encountered discrimination.

"The first chief nurse I had in the Army was dead-set against male nurses. I guess that was her chance to lord it over men."

He also had to abandon his choice of speciality.

"I wanted to be an obstetrics nurse and was told I couldn't be."

He settled on community health nursing, a field he has found very satisfying.

"To me, the thrust of nursing is outside the hospital. We make our greatest contribution in the community. And the field is so varied. It invites you to be a true nurse generalist."

He worked extensively with patients who have AIDS and other sexually transmitted diseases — interviewing the sick, monitoring treatment and promoting public awareness.

While stationed in Germany, he devoted much of his time to curbing child abuse.

"I was very much overwhelmed by the child abuse situation while in Germany," he said. "These were young military families who were away from their home and family, their support system, and their neighbors didn't even speak their language. Some of them would vent their frustrations on the most available person — their child."

He found help for such families to be inadequate. "It was at a time when we were just beginning to identify child abuse as a critical medical entity. I proved to my military commander that we needed a social worker there."

The social worker was hired, and she and Mr. Marcotte helped establish a foster care program in the country for emergency situations.

Community nursing kept him in constant contact with the public, and time and time again, he was reminded of his minority status. "People outside the profession are used to seeing women as nurses. Sometimes, they don't believe me. I get called doctor a lot and have to remind them that I'm not a doctor."

Nor does he wish to be. "I view my family (a wife, five children and a grandchild) as an important part of my being. It's too disruptive to be on call all the time."

He also prefers the nurse's role in the healing process. "My definition of nurses as opposed to physicians is that nurses are involved in wellness. We promote wellness and teach people how to stay healthy. And in hospitals, we promote patients to get better. We contribute to a sick person in a unique way; we attend to needs they can't handle."

He acknowledges that women and men bring different strengths to nursing.

"I think by and large, women by their nature project a more caring and feeling attitude than men. Men nurses probably have more problems dealing with a patient on a feeling level. But the personality of men and women nurses kind of runs the spectrum. We each bring our unique selfness to the profession."

Mr. Marcotte retired from the Army in 1986 and enrolled at MCG the same year. He's seeking a master's of science degree in nursing. As usual, he's outnumbered ("I'm usually the only male in my classes") but as usual, he's not complaining.

"You're really recognized as a true professional in your field if you have your master's to back it up with. And it gives me credentials as a researcher."

He also is serving as project director for the CSRA Prematurity Prevention Program, in which high-risk pregnant women are identified and helped to carry their babies to full term. If the program succeeds in three test counties — Burke, McDuffie and Richmond — it will be implemented statewide.

"I'm really excited about the program. It's what everybody who wants to be a nurse dreams about — doing something really significant." ■

Jerry Marcotte with Pat Hayes and Margaret Kelsey in the Maternity and Infant Clinic ►

MEMOREX
MOREX

From homemaking and odd jobs to a career in dentistry

By John Donnelly

Hanging wallpaper is an unusual first step toward dental school. Andrea Garmon has taken more than one unusual step in pursuing her dental education, however.

"I was trying to decide on a career that would hold my interest and in the meantime doing odd jobs," recalled Mrs. Garmon, 37, now a sophomore in the Medical College of Georgia School of Dentistry.

"One of the jobs happened to be hanging wallpaper in a dentist's office. I started talking to him and ended up thinking dentistry was something I could stay interested in."

Quite a change for a woman who never expected to be in the workforce.

"I graduated from college in 1971 with a degree in home economics. All I wanted to do was start a family and raise my children — Suzanne, 14; Bill, 13; and Misty, 8," she said. Well, maybe that was not all she wanted to do. Mrs. Garmon liked to work with her hands and had turned it into a profit-making sideline.

"While the children were still at home, I began making dolls, quilts, toys, things like that, for craft fairs around Atlanta. It was something I could do at home and something I enjoyed doing," she said.

When the children were all of school age, however, Mrs. Garmon's energy needed new outlets.

"I started looking for something else to do, but it was hard to find something that I felt would hold my interest over the long run. Also, some fields were not economically feasible," she said.

Then she met Dr. Gary Sabin.

"He was so enthusiastic about dentistry when I started talking with him, he really made it seem worthwhile," Mrs. Garmon said.

Further conversations and research convinced her she had found a field that would hold her interest. The reality of getting into dental school, however, required more of a commitment than she had imagined.

"I spread out my prerequisites over two years, until Misty was in first grade. I was attending Georgia State University and working part time in Dr. Sabin's office. The Emory dental school was the only one I applied to because I didn't want to leave the Atlanta area. We were living in our 'final house' in Lawrenceville and Norris, my husband, had just begun a new job with Oglethorpe Power," Mrs. Garmon explained.

The good news arrived in December 1984. She had been accepted at Emory. Better news followed in January 1985. Mrs. Garmon received a scholarship which paid $8,000 in the first year.

Two days later a friend called her to ask what she was going to do. "She had seen on the early news that Emory was closing their dental school and assumed I had been contacted by the school before the announcement was made. It was quite a shock," Mrs. Garmon said. A notice from the school arrived the next day.

Mrs. Garmon then called the Medical College of Georgia School of Dentistry to see about admission. "I was concerned about getting into dental school, but I figured the worst that could happen was that my getting in would be delayed a year," she said.

Because she wanted to attend dental school in Atlanta, Mrs. Garmon had not applied to any other dental schools. This did not weigh in her favor.

"I was told by the MCG dental school that I could apply, but that first choice would go to students who had previously applied." She applied anyway.

"While this was going on, I received a call from the Medical College of Virginia dental school asking if I would come up and interview. They told me up front that my chances would rest on the number of already accepted students who decided to attend MCV. I interviewed in Richmond and then, two weeks later, they wrote and told me the class had been filled," Mrs. Garmon said.

The MCG dental school had by this time changed its position. Six Georgia residents who had been accepted at Emory would be admitted at MCG.

"When I found that out, I interviewed in Augusta and was accepted at the beginning of April. It was quite a relief," she said. An added relief was discovering that Emory would honor Mrs. Garmon's scholarship. Life for the Garmons began to fall into place.

"I knew it would be a big adjustment moving the family to Augusta," Mrs. Garmon said, "but everything worked out very well."

Mr. Garmon, a mechanical engineer, was able to find employment with the Georgia Tech Research Institute in Augusta where he is a trouble-shooter for local industries.

"The house we got here turned out to be in a very good location as far as the children are concerned," Mrs. Garmon said. "The schools are very close."

The family did not give up the house in Lawrenceville, Mr. Garmon said. "The house is on four and a half acres of land and is rented until Andrea gets out of school," he said. The decision on returning to Lawrenceville will await Mrs. Garmon's graduation.

For now, moving to Augusta has meant adapting to a smaller house and "leaving a lot of furniture" behind, Mrs. Garmon said.

At-home studying with three children in the house has not really been a problem for Mrs. Garmon. "I block out pretty well. Sometimes I'll study at the table in the evenings and help the kids with their homework and then get back to mine. They are pretty good about letting me study," she said.

Although she has not picked an area of concentration, Mrs. Garmon is partial to the esthetic dentistry she first encountered in Dr. Sabin's office.

"Of all I've done since I've been here, I have really enjoyed esthetic dentistry. I just like working with my hands. Doing that type of dentistry would be an added pleasure," she said. ■

◄ *Andrea Garmon*

COMPARING NOTES

Dental clerkship a 'foreign' experience for Rick Marlow

By John Donnelly

Rick Marlow learned quickly that in parts of Europe, calling a physician or dentist "doctor" was considered an insult.

"They are called doctor while they are in dental and medical school, but by the time they begin their speciality training, they are called mister," he said.

This was just one interesting bit of information Mr. Marlow, a senior dental student, picked up in Europe while completing a public health clerkship required by MCG's dental school. The program provides junior and senior students with off campus dental experience during the summer.

Nearly all students do clerkships closer to home than Mr. Marlow.

"The majority of the students do their clerkships in Georgia," said Dr. Earl Williams, chairman of the department of community dentistry and the program's coordinator. Sites include the Ben Massell Clinic in Atlanta, the Westside Urban Health Center in Savannah, Central State Hospital in Milledgeville and the Chatham County Health Department in Savannah.

Several students each year pursue clerkships with the Indian Health Service, working on Indian reservations throughout the country while others choose U.S. Coast Guard posts. In the summer of 1985, students worked at the Indian reservation in Pine Ridge, S.D., and at Coast Guard stations in New York, North Carolina and Alaska.

Mr. Marlow's was not the first clerkship to take place outside the United States, however. Every year students accompany Dr. William Wege (professor of oral medicine at the dental school) to Central America or the Dominican Republic. Students have also accompanied mission groups to Africa.

"We feel the public health clerkship is a very good program for the students," said Dr. Williams. "They have the chance to work in clinic settings under less supervision than in the dental school clinics."

"Rick's experience really was unique," the program coordinator said. "Not only did he work in two countries, but he was able to work in his area of special interest — oral surgery."

Mr. Marlow spent eight days at Canniesburn Hospital, the plastic and oral surgery center for western Scotland, and six days with the private practice of Mr. Paul V.W. Stoelinga in Arnhem, Netherlands.

The experience gave him insight not only into the usual cultural differences, but also into alternative methods of dental practice.

In Scotland, Mr. Marlow found that one cultural difference created some unexpected cases.

"The facial trauma a dentist sees in Scotland is different from that in the U.S. because the Scots have fewer cars," he said.

Instead, Mr. Marlow encountered a phenomenon called the "Glasgow kiss." When a Scotsman gets into a fight, he uses his head to butt his opponent's face, Mr. Marlow explained. The results are broken cheekbones and trauma to the upper jaw.

"They see more of this in a month than dentists in the U.S. would see in a year," Mr. Marlow said.

"During the time I was in Scotland I got to do a lot of surgery that I would not have gotten to do here," he said. His surgical experience included a night at the Royal Casualty (emergency) room where he assisted in surgery cases.

What he saw in Scotland does not mean a dental student would rush to adopt all those dental practice methods.

"For example, their procedure for extracting third molars (wisdom teeth) would leave half the tongue permanently numb. This would be unacceptable here," Mr. Marlow said. "They also show almost no tact while discussing a patient in his or her presence."

The dental student had to adapt to differences as basic as instruments.

"When I first went into surgery in Canniesburn, they were using instruments I had not even seen before," Mr. Marlow said. He also noted differences in procedures and even the oral surgeon's position while operating.

In the U.S., oral surgeons always stand to the right of the patient. In Scotland, oral surgeons stand on the side of the patient which was most convenient, according to Mr. Marlow.

"Some of the other students were very interested in the techniques I used," Mr. Marlow said. "I am sending a couple of students I met in Scotland some of the instruments we use here."

Schooling for dental students also differs from that in the U.S., Mr. Marlow said.

"In England, they enter dental school from high school and attend for five years. Following that, they attend medical school for four years and then do their speciality work. All of the oral surgeons over there are M.D.'s."

In Mr. Stoelinga's Arnhem, Netherlands, practice, Mr. Marlow said he didn't get to work with patients as much. "They were more worried about lawsuits there than in Scotland. Most of what I did was observe," he said. "Mr. Stoelinga spoke flawless English and would stop during the procedures he was performing and explain, in English, what he was doing. He also took time out from his clinic to drive me to the train station when I left. That impressed me."

While his experience in the Netherlands was rewarding, Mr. Marlow said, "if I had the trip to do over, I would stay two weeks to a month in Scotland. The people of Glasgow were the friendliest people in Europe!" ■

Rick Marlow crossed the North Atlantic Ocean to spend his dental clerkship in Scotland and the Netherlands ►

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LESSONS LEARNED

Home health care teaches nursing student about life

By Christine Deriso

Julie Jenkins, a petite, brown-eyed graduate student at the Medical College of Georgia, has had more experience with death and suffering in her 28 years than most people have in a lifetime.

Since graduating with a nursing degree from Clemson University in 1981, her career in hospice and home care has brought her into daily contact with the elderly, handicapped and terminally ill.

"Who knows how I got involved?" she said. "My daddy's a farmer, my sisters are in business... I wonder myself."

Actually, she doesn't have much time to ponder her situation; she's too busy living it. She works an eight-hour day at Augusta's Comprehensive Health Home Care Inc. (to which MCG often refers patients) and attends classes in the evening. She'll graduate this spring with a master's in nursing.

She works with elderly people who need home care but otherwise are able to take care of themselves.

"My work is designed to keep people out of nursing homes," she said. "I check their medicine and blood pressure and make sure they have adequate heating and lighting."

Miss Jenkins said her visits last from 10 minutes to an hour, and she sees as many as 15 patients a day.

"My friends have asked me how I can walk up to all those strangers' doors," she said. "But they're always grateful that I'm there, and I've never come across a situation I couldn't handle."

She conceded, however, that the situations are getting more complex since rising health-care costs are resulting in increasing emphasis on home care.

"You start seeing people at home with IV's and respirators. They're sicker at home now," she said.

She also mentioned a patient whose home is unsanitary and who occasionally forgets to turn off her stove. She can refer such patients to community services or hospitals if she feels home care is insufficient.

For the most part, however, most of her patients do quite well and need only short-term care from her.

Such was not the case with some of Miss Jenkins' earlier experiences.

"The things that make me saddest are really sick children," she said. She worked with them, along with other terminally ill people, before switching to work with the elderly.

She recalled one dying infant whose parents bravely carried on as normally as possible.

"We went to the same church, and they'd bring her to church every Sunday, all dressed up. I'd cry all the way through the service; nobody else knew what I knew."

She said she still sometimes has a hard time controlling her feelings in some situations.

"Some days, it really bothers you. You have to really make an effort to leave it at work. You have to leave your feelings at the door."

Despite the sadness, she said she's learned a lot from her patients.

"They make you realize you can't really count on the future. You live for the day, and don't go to bed at night mad at anybody."

She's also health conscious beyond her years, having witnessed the devastating effects of bad habits - chiefly smoking.

"I've seen people on their death beds, dying of lung cancer, and they're smoking imaginary cigarettes."

But the positive aspects of her patients' lives have made the biggest impression.

"My patients have taught me a lot about life. I love to listen to their stories;

Julie Jenkins teaches Marie Brown how to check her sugar level

they always have something to tell you about things that happened 50 years ago. I've always thought I should write a book about all these people I see. The only problem is I can't write."

She said the most important things she's learned couldn't be put into words anyway.

"They've taught me how to live and how to die, and how to laugh."

Miss Jenkins hopes to work in management or consulting once she has her master's degree. She never thought she'd get this far in nursing, having originally decided to try the field for two years, then move on to somthing else.

"But I liked it, so nursing was the right decision," she said.

She's not sure what drew her to the field, but she thinks she's discovered what it takes to make a success of it.

"You have to be practical and realistic. You have to realize you can't save the world. Once you realize that, the rest is easy." ■

LEARNING: *A way of life*

Since Noriko Akamatsu first set foot on American soil in 1977, her willingness to learn and adapt has kept her family afloat and set her on her way to a new career.

By Catherine Boardman

Noriko Akamatsu was intrigued by the laboratory where her husband worked as a cancer researcher at the Medical College of Georgia. On weekends she helped him feed the lab animals. Her interest piqued, she decided to learn more about the medical field.

She began classes at Augusta College with plans to transfer to MCG after completing basic English, math and science courses.

Mrs. Akamatsu also hoped that going to school would ease her adjustment to life in a new society. The Akamatsus moved to Augusta from Japan in 1968 when Dr. Yasuyuki Akamatsu accepted a job at the Medical College of Georgia. "My husband and I thought that if I went back to school, my English would improve and I would better understand the American way of life," she said.

That was in 1977 and things have changed. A year later, Dr. Akamatsu died of cancer, the same disease he had dedicated his life to researching. Mrs. Akamatsu was faced with many decisions and adjustments to make.

"I was just an ordinary housewife with three small children when my husband died," Mrs. Akamatsu said. Suddenly she was a single parent raising three children in a new society. "I was anxious to go back to Japan. I was really homesick," she said. Mrs. Akamatsu stayed because she felt her children would receive a better education in the United States than in Japan. Also, her children spoke English fluently but knew very little Japanese.

She managed financially because of her husband's retirement and Social Security benefits. Also, Mrs. Akamatsu found a job in the Department of Cell and Molecular Biology at the Medical College of Georgia and later at the School of Dentistry.

Mrs. Akamatsu has no regrets about staying in the United States. In fact, she says that seeing her children graduate from high school gave her a real sense of accomplishment. She has much more to be proud about. Her oldest child, 25-year-old Yuki, is a senior medical student at the Medical College of Georgia and plans to specialize in pathology. Maho, 21, is a senior majoring in microbiology at the University of Georgia. Seventeen-year-old Ken is a senior at Aquinas High School in Augusta.

With so many students in the family, Mrs. Akamatsu is comfortable being a student herself. She chose to study medical technology because she wants to work as a laboratory technician in a research lab.

Medical technologists are clinical laboratory professionals who test blood, body fluids and tissues. Test results are used by physicians to diagnose and treat patients. Medical technologists work in industry, research and education as well as hospital laboratories and private clinics.

Mrs. Akamatsu will graduate from the Medical College of Georgia School of Allied Health Sciences in May and hopes to find a job in Augusta. In the meantime she's busy going to class and studying. She occasionally meets Yuki at school.

Having her mother on the same campus is convenient at times, Yuki said. Sometimes their schedules work out so they can eat lunch together. "But usually we're on such different schedules that it's like we're at different schools," Yuki said.

Mrs. Akamatsu says a strong interest in what she is doing keeps her going as she struggles to be mother, student and head of the Akamatsu household. She studies early in the morning so she has time to devote to her children at night. Also, since English is not her native tongue, Mrs. Akamatsu likes to study in the morning when she is rested and can concentrate better.

She enjoys being with younger students. "It's a funny feeling. Sometimes I feel so old and out of place. I think, why am I here, I shouldn't be here. But in the classroom and when I am studying, I forget my age," Mrs. Akamatsu said. ■

Noriko Akamatsu and her daughter Yuki ►

Where there's a will there's a way

Students find money for school from a variety of sources

By Catherine Boardman

Students are notoriously poor. Some receive money from their parents, some rely on their own savings, some work while in school, but most Medical College of Georgia students receive some type of financial aid.

The cost of school makes that no surprise. Average costs for the first year, including tuition and living expenses, for a single student living on campus at the Medical College of Georgia are: School of Allied Health Sciences — $6,997, School of Dentistry — $14,482, School of Graduate Studies — $8,191, School of Medicine — $10,565, School of Nursing — $6,811.

At the Medical College of Georgia, 68 percent of the student body received financial aid in 1985-86. The student financial assistance program provided more than $7 million to 1,310 students, a 2 percent increase over the previous year. The money came in the form of grants, scholarships, loans, service commitment programs and employment.

Several options exist for students who want a health care career but who can't afford the necessary training. Cheryl W. O'Keeffe, director of the student financial assistance program at the Medical College of Georgia, takes on a "where there's a will, there's a way" attitude when helping students finance school.

"We work with each individual student and help identify all possible funding sources. We will get a student through school one way or the other," she said.

The biggest source of funds is the guaranteed student loan program. The federally-funded loans are administered through lending institutions such as commercial banks, savings and loans, and employee credit unions. For 1987-88, a maximum of $7,500 may be borrowed each academic year by graduate and professional students with a cumulative loan ceiling of $54,750. Undergraduate students may borrow $2,625-$4,000 each year with a cumulative maximum of $17,250.

The average interest rate on guaranteed student loans is 8 percent. Normally, the repayment period begins six months after graduation and extends for five to 10 years. While the student is in school, the government pays interest to the lender and the student does not have to repay this interest.

All students applying for financial aid at the Medical College of Georgia are instructed to apply for a guaranteed student loan.

"It keeps us afloat. Approximately 50 percent of our students borrow under that program," Mrs. O'Keeffe said.

Undergraduate students who do not hold baccalaureate degrees apply for Pell Grants. The federally-funded grants range from $200 to $2,100 but do not exceed 60 percent of education costs. Last year, 132 students qualified for grants which averaged $1,396.

Also, Georgia Student Incentive Grants, which average $394, are available for Georgia residents enrolled in associate and baccalaureate programs in allied health sciences and nursing programs.

When students need more money than is available through the guaranteed student loan program, Pell Grants and Georgia Student Incentive Grants, they may apply for Medical College of Georgia assistance. Federal, state and private funds are awarded through the department of financial assistance.

However, those funds are limited. Federal grants to the Medical College of Georgia in support of student financial aid totalled $407,000 in 1985, a 14 percent drop from 1984's allocation. Formulas used to allocate Department of Education funds tend to favor newer institutions and private schools, Mrs. O'Keeffe said.

"We are totally dependent on the federal government. If you look at the dollars available for student aid, in some way the federal government is involved in 70 percent of those dollars. Anytime you have an administration that is not favorable to student aid, you have a very difficult problem," Mrs. O'Keeffe said.

Priorities continuously shift and there are never any guarantees that student financial aid programs will be intact from year to year, Mrs. O'Keeffe said. The Medical College of Georgia department of financial assistance must play a waiting game with Congress each year before any promises about financial assistance can be made to students.

"The state could do more in terms of student financial aid than it is currently doing," Mrs. O'Keeffe said. However,

Getting by means loans and part-time jobs

Cathleen Fox, a sophomore dental student from Atlanta, has a work/study job and works once a week and every other weekend managing the game room at the student center on campus. "I qualified for a work/study job, but with dental school, I wasn't sure how much time I would have. They found the perfect job for me because it's at night and on the weekends. When it's not busy, I can study," Miss Fox said.

Miss Fox also has three loans — a guaranteed student loan, a health professions student loan and a Georgia state direct student loan. The health professions student loan, a federal loan program for medical and dental students, is awarded by the Medical College of Georgia.

Miss Fox won't have to pay back her state direct student loan if she practices in an approved area. But with most student loans, debt inevitably follows. Miss Fox says she thinks about the debt she will have after graduation but doesn't dwell on it.

Mark DeGuenther, a sophomore medical student from Atlanta, agrees. "Naturally you think about it — you're going to be in $30,000 to $40,000 debt when you get out of school."

Mr. DeGuenther prefers to think of his guaranteed student loan as an investment. "If you are going to make anything in the world, you've got to take some risks."

Cathleen Fox

Mark DeGuenther

To earn extra money, Mr. DeGuenther works in the pulmonary blood-gas laboratory at the Medical College of Georgia Hospital. His job is not part of the federally-funded work/study program.

Both Miss Fox and Mr. DeGuenther agree that cost should not be a deciding factor when considering a health career. "Medical school is something I wanted to do and I knew I could finance it," Mr. DeGuenther said. Miss Fox is thankful for the financial aid she has received. "It would have been really hard on my family otherwise," she said. ■

even most state student financial aid programs are dependent on federal funds, she said.

"The state does a tremendous job supporting student financial aid bearing in mind the budget constraints legislators have to act within," said state Rep. Thomas Buck, chairman of the University System of Georgia Committee and representative of the 95th district. State funds for health career students are available through programs such as state direct student loans, osteopathic medical loans, the medicine loan program and regent's scholarships.

Under the state health careers student loan program, students may cancel each academic year's loan with one year's work in an approved area, usually rural areas, in the state. Since Georgia has no school offering osteopathic medicine, loans are made to students to attend such schools in other states. Students must return to Georgia and practice to repay the loans. The State Medical Education Board receives state funds for scholarships. In 1985, 135 medical students received scholarships ranging from $3,750 to $6,000 per year. Scholarship recipients agree to practice in rural areas of Georgia for five years. Sixty-five percent of 1985's recipients attend the Medical College of Georgia.

The area of private donations has the most growth potential at the Medical College of Georgia in terms of student financial aid, Mrs. O'Keeffe said. "It's really sad. We just cannot be competitive with other institutions as far as what we can offer in terms of scholarship programs," she said.

Scholarship money that is available is effectively dispersed, Mrs. O'Keeffe said. She and other members of the financial assistance staff work with scholarship committees in each school to award scholarships and establish policies for allocating institutional money to help students.

Also, the financial assistance department helps students find jobs. A federally subsidized college work/study program is available. The program is based on need. Another program, not based on need, helps students find jobs at the Medical College of Georgia Hospital and other places in the community. ■

Thanks to SGA

Campus life more rewarding - and fun

By Terri Hinner

When the Medical College of Georgia students attend a TGIF party, work out in aerobics class, or enjoy many of the other activities at MCG, they have proof their student activity fee has been put to good use.

The Student Government Association operates solely on funds from the student activity fee which is $17 per quarter. But distribution of the activity fee is only one of the many concerns of the SGA.

"We try to coordinate programs to bring the students in each school together while acting as a liaison between administration, faculty and students," said Frank Carter, SGA president.

All money received from student activity fees goes to the SGA, but the money is returned to students in the long run.

"To a lot of students the SGA is known as a source of entertainment because we sponsor the TGIF parties, aerobics, intramural sports, the school newspaper and many other activities," said Mr. Carter.

Most SGA-planned events are popular with students, despite the time they spend studying, said Mr. Carter, a senior medical student.

"It's hard to believe the students at MCG have time for anything but studying, but the TGIF's are always full," Mr. Carter said. "Also we are very proud of how popular the aerobics class has become, considering it's only in its second year of existence at MCG."

Enthusiasm is also apparent at MCG. "It's very rare to go to a school costume party where 80 percent of those attending are dressed up, but MCG always has a lot of participation at their Halloween parties," Mr. Carter said.

While the SGA serves all students, being a member is particularly advantageous.

"The SGA can be used as a training ground for self-government," said Dr. James B. Puryear, vice president of student affairs. "It teaches members a certain type of leadership while they are students which will be useful to them out in the professional world."

SGA members are elected yearly from each school, one representative per 50 students (there are 45 members this year). Meetings are held once a month and are open to everyone. Officers include Mr. Carter as president, Jack Green, vice- president; Rebecca Burnett, secretary; and Bill Kapp, comptroller.

This year the SGA has completed its park project located in front of the MCG library. The project took four years to complete and was partly funded by SGA.

"The students came up with the idea of wanting to do something to help beautify the school and money from SGA went to help fund the project," Dr. Puryear said. "The grounds people of MCG actually planned and constructed the park, making it an entire in-house project."

In the future the SGA would like to establish an athletic fee to fund the construction of a gymnasium for the students of MCG. Though it is only in the planning stage and there are many other priorities for the school, the SGA is still hopeful.

"For one of the four major universities in Georgia to call a high school to ask permission to use their school for intramural sports, you really have to swallow your pride," said Mr. Carter. "A gym is definitely needed at MCG for intramurals and for anyone who just wants to get some exercise." ■

Frank Carter meets with Dr. Jesse Steinfeld

Giving

Supporters of the Medical College of Georgia are being encouraged to name MCG Foundation, Inc. as the beneficiary of gifts in wills and other trust arrangements.

The Board of Regents of the University System of Georgia recently requested that individual colleges and universities within the system encourage their supporters to name tax-exempt foundations at particular schools as beneficiaries of such gifts. This procedure is expected to ease the administrative aspects of managing the gifts.

A gift made to any unit within the system is technically the property of the Board of Regents. The regents take official action to designate gifts for their intended purposes.

Officials at MCG created MCG Foundation, Inc. in 1954 to administer its gifts. If you have provided for the Medical College of Georgia in your will, please check with your attorney to insure the Medical College of Georgia Foundation, Inc. is properly named.

If you are now preparing your will and are considering naming MCG as a beneficiary, feel free to contact our offices at (404) 828-2515 for assistance. We can provide information on designating uses for the funds, honoring loved ones, receiving tax benefits or other aspects you and your attorney may discuss.

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